

Distribution: HCFA 1500/837 Professional Providers – MSA 02-08
(*See Manual Maintenance for Bulletin Number Distribution*)

Issued: April 1, 2002

Subject: Chapter IV HCFA 1500/837P Billing and Reimbursement

Effective: Upon receipt

Programs Affected: Medicaid, Children's Special Health Care Services,
State Medical Program

The purpose of this bulletin is to transmit a complete up-to-date Chapter IV to all providers who bill on the HCFA 1500/837 P (professional) claim format. The complete Chapter IV represents a milestone in the Uniform Billing Project undertaken by the Department of Community Health early in 2001. The Department has successfully transitioned to the national standard billing formats of the HCFA 1500 paper claim and the ASC X12N 837 professional electronic claim (currently version 3051 or the Michigan Medicaid interim 4010). The Department will continue to work toward full HIPAA compliance in the months to come and will keep providers informed of the status of this important project.

The following updates have been incorporated in the full Chapter IV:

- This Chapter IV applies to all providers who bill on the HCFA 1500/837P claim format. A list of the various provider groups is included in Section 1, page 1.
- Special Billing Instructions and Modifiers for providers in the Phase II Uniform Billing Project previously published in MSA 01-23 are incorporated in the chapter.
- Place of Service codes are updated to include the changes recently published by CMS (Center for Medicare and Medicaid Services).
- Modifiers GY and GZ replace modifier GX and modifier GM replaces YZ effective for 2002. Modifier 60 is deleted.
- DCH e-mail addresses are changed. The second node of e-mail addresses is changed from @state.mi.us to @Michigan.gov. Please update your address books accordingly.
- Section 3, HCFA1500/ASC X12N Crosswalk is deleted. The specific transaction specifications or Implementation Guide for the version being submitted to the DCH must be followed. Information on the electronic transaction specifications are on the DCH website as explained in the manual material. As versions change, the website will be updated with the appropriate information.

- Section 8, Remittance Advice, directs providers to the DCH website for information on the electronic RA.
- Section 10, Help, has been updated to reflect current information.

Manual Maintenance

Bulletin distribution and numbering by provider manual:

Ambulance 02-02, Chiropractor 02-01, Community Mental Health Services Program 02-04, Family Planning 02-03, Federally Qualified Health Centers 02-04 and Indian Health Centers 02-04, Hearing Aid Dealers 02-03, Hearing and Speech Centers 02-03, Laboratory 02-02, Maternal and Infant Support Services 02-01, Medicaid Health Plans 02-05, Medical Supplier 02-01, Practitioner 02-05, Rural Health Clinic 02-03, Vision 02-02.

Discard the entire Chapter IV, Billing and Reimbursement, and replace with the new Chapter IV, HCFA 1500/837 P Billing, manual pages attached to this bulletin. The date for your Chapter IV should be 4-1-02.

The following bulletins are obsolete and should be discarded:


- MSA 01-01 for Ambulance, Chiropractors, CMHSPs, Family Planning, Laboratory, Maternal & Infant Support, Practitioner, Vision, and School Based Services Providers
- MSA 01-20 for Ambulance, Chiropractors, CMHSPs, Family Planning, Laboratory, Maternal & Infant Support, Medicaid Health Plans, Practitioner, Vision, and School Based Services Providers
- MSA 01-23 for Hearing Aid Dealers, Hearing and Speech Centers, Medical Suppliers, FQHCs, RHCs, IHCs

You may discard this bulletin after manual maintenance.

QUESTIONS

Any questions regarding this bulletin should be directed to: Provider Inquiry, Department of Community Health, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

APPROVED



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INTRODUCTION

This chapter contains the information needed to submit professional claims to the Michigan Department of Community Health (DCH) for Medicaid, Children's Special Health Care Services (CSHCS), and the State Medical Program (SMP). It also contains information about how we process claims and how we notify you of our actions.

The following providers must use the ASC X12N 837 professional format when submitting electronic claims and the HCFA 1500 claim form for paper claims:

- Ambulance Providers
- Certified Nurse Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Chiropractors
- Community Mental Health Service Programs
- Family Planning Clinic Providers
- Federally Qualified Health Centers
- Hearing Aid Dealers
- Hearing and Speech Centers
- Independent Lab Providers
- Indian Health Centers
- Maternal and Infant Support Service Providers
- Medical Clinics
- Medical Suppliers
- Optical Companies
- Optometrists
- Oral Surgeons
- Orthotists and Prosthetists
- Oxygen Suppliers
- Physical Therapists
- Physicians, MD & DO
- Podiatrists
- Rural Health Clinics
- School Based Service Providers
- Shoe Stores

CLAIMS PROCESSING SYSTEM

All claims submitted are processed through the Claims Processing (CP) System. Paper claims are scanned and converted to the same file format as claims submitted electronically. We encourage claims to be sent electronically by file transfer or through the data exchange gateway. Electronic filing is more cost effective, more accurate, payment is received more quickly, and administrative functions can be automated.

The CP System consists of several cycles:

The daily cycle is the first set of computer programs to process all electronic and paper claims. The daily cycle is run four to five times each week and performs a variety of intra-claim editing (e.g., provider and beneficiary eligibility, procedure validity). All claims are reported out as tentatively approved, pending, or rejected.



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The weekly cycle is run once each week using the approved claims from the daily cycles that were run during the previous seven days. The weekly cycle includes inter-claim editing using an historical file of all claims paid during the previous 24 months. Inter-claim editing includes duplicate claims, procedures with frequency limitations, combination of service edits, etc. The provider's check (warrant) and remittance advice (RA) are generated from this cycle. All claims are reported out as approved for payment, pending, or rejected.

REMITTANCE ADVICE

Once claims have been submitted and processed through the CP System, a remittance advice (RA) will be sent to the provider and to the billing agent if applicable. See the RA section of this chapter for additional information about the paper RA. Information about the electronic RA can be found in the MDCH Electronic Billing Manual on the DCH website.

ADDITIONAL RESOURCE MATERIAL

Additional information needed to bill may include:

Provider manuals: These manuals include program policy and special billing information. Provider manuals and other program publications are available at a nominal cost from DCH. See Section 10 for information on ordering manuals and publications.

Bulletins: These intermittent publications supplement the provider manual. The bulletins are automatically mailed to subscribers of the affected provider manuals. Recent bulletins can be found on the DCH website.

Numbered Letters: General program information or announcements are transmitted to providers via numbered letter. These can be found on the DCH website.

Remittance Advice Messages: RA messages are sent to specific provider groups with the remittance advices and give information about policy and payment issues that affect the way services are billed and paid.

Medicaid Databases: These list procedure codes, descriptions, fee screens, and other pertinent coverage, documentation, and billing indicators. They are available on the DCH website.

Note: Find the DCH website at www.mdch.state.mi.us. Click on *Medical Services Administration* and proceed to *Provider Information*.

CPT and HCPCS Codes: You must purchase these two publications annually listing national CPT and HCPCS codes. The publications are available from many sources, such as the AMA Press at 1-800-621-8335 or Medicode at 1-800-999-4600.

International Classification of Diseases (ICD-9-CM): Diagnosis codes are required on your claims using the conventions detailed in this publication. This publication should be purchased annually. It may be requested from Medicode at 1-800-999-4600, or the AMA Press at 1-800-621-8335.

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HOW TO FILE CLAIMS

You may submit your claims **electronically** or on **paper**. Electronic claim submission is the method preferred by DCH.



ELECTRONIC CLAIMS

Claims submitted electronically are entered directly into the Claims Processing System resulting in faster payments, and fewer pends and rejects. Claims can be submitted by file transfer or through the data exchange gateway. The electronic claim format is the ASC X12N 837 professional. Providers must use the version(s) accepted by DCH.

For information on submission of electronic claims, go to the DCH website at: http://www.mdch.state.mi.us/msa/mdch_msa/UniformBilling/index.htm. The MDCH Electronic Billing Manual is located there. Information will be updated on the website as version changes occur at the national level and the department adopts those changes.

AUTHORIZED BILLING AGENTS

Any entity (service bureau or individual provider) that wishes to submit claims electronically to the DCH must be an authorized billing agent. The authorization process is easy:

1. Contact the DCH Automated Billing Unit for an application packet. (See information below.)
2. Complete and submit the forms in the application packet (an application and a participation agreement).
3. Receive an identification number.
4. Format and submit test files.
5. Once test files are approved, receive full authorization from DCH to bill electronically.

Once you are an authorized electronic billing agent, any provider (including yourself) who wants you to submit claims on their behalf must complete and submit the Billing Agent Authorization (DCH-1343) form to the DCH. This form certifies that all services the provider has rendered are in compliance with Medicaid's guidelines. We will notify each provider when it has been processed. After notification, you can begin billing electronically for yourself or other providers that have been approved to use you as their billing agent. Only one billing agent per provider will be authorized to submit the provider's claims on Electronic File. Authorizations remain in effect unless otherwise indicated in writing by the provider.

The electronic billing agent authorization process, specifications for test files, specific information about electronic billing and the transaction set for professional claims can be found on our website. Test claims will not be processed for payment. Any live claims for services rendered must be billed on paper until the DCH-1343 process is complete.

Any individual provider can submit claims electronically as long as the authorization process is met, however, many providers find it easier to use an existing authorized billing agent to submit claims to the program. The billing agent takes claim information gathered from all of its clients and formats it to DCH



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standards. The data are then sent to the DCH for processing. Whether you submit claims directly or through another authorized billing agent, you will receive a remittance advice (RA), which reflects your individual claims. Your billing agent will receive an RA that contains information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents:



E-mail: AutomatedBilling@michigan.gov



Or write to:

Michigan Department of Community Health
Medicaid EDI Billing Coordinator
P. O. Box 30043
Lansing, MI 48909-7543

Note: If comments or additional information is required with a claim, electronic billers must enter the information in the appropriate segments of the electronic record. If an operative report or other paper document is required to be submitted with the claim, an electronic claim cannot be submitted. Claims that require extraneous attachments must be submitted on a paper HCFA 1500 claim form. Refer to Providing Attachments With Paper Claim Forms later in this section for more information.



PAPER CLAIMS

When submitting paper claim forms, use the HCFA 1500 form. It must be a red ink form with the numbers (12-90) RRB-1500 in the lower right corner. The version with the four black alignment bars in the upper left corner is the preferred version. Paper claims are scanned by our Optical Character Reader (OCR).

Claims may be prepared on a typewriter or on a computer. We will not accept handwritten claims. The claims are optically scanned and converted to computer data before being processed. Print problems may cause misreads by our scanning equipment thus delaying processing of your claim. Keep equipment properly maintained to avoid the following:

Dirty print elements with filled character loops.

Light print or print of different density.

Breaks or gaps in characters.

Ink blotches or smears in print.

Worn out ribbons. Mylar (plastic film) ribbon is preferred on dot matrix printers.

Questions and problems with the compatibility of your equipment with our scanners should be directed to the OCR Coordinator at:



Michigan Department of Community Health
Attn: OCR Coordinator - Operations
3423 N. MLK Jr. Blvd.
Lansing, MI 48909

OR



E-Mail Address: OCRCoordinator@michigan.gov



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GUIDELINES TO COMPLETE PAPER CLAIM FORMS

The following guidelines are to be used in the preparation of paper claims to assure that information contained on the claims is correctly read by the scanning equipment. Failure to adhere to the guidelines may result in processing/payment delays or claims being returned unprocessed.

- Dates must be eight digits without dashes or slashes in the format MMDDCCYY (e.g., 03212000). Be sure the dates are within the appropriate boxes on the form.
- Use only black ink. Do not write or print on the claim, except for the Provider Signature Certification.
- Handwritten claims are not acceptable.
- Any alphabetic characters must be UPPER CASE only.
- Do not use italic, script, orator, or proportional fonts.
- 12 point type is preferred.
- Make sure the type is even (on the same horizontal plane) and within the boxes.
- Do not use punctuation marks (e.g., commas or periods).
- Do not use special characters (e.g., dollar signs, decimals, or dashes).
- Only service line data can be on a claim line. DO NOT squeeze comments below the service line.
- Do not send us damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- Do not use White-Out or correction tape.
- If you make a mistake, start over and prepare a "clean" claim form.
- Do not submit photocopies.
- Claim forms must be mailed flat, with no folding in 9" x 12" or larger envelopes.
- Put your return address on the envelope.
- Separate the claim form from the carbon.
- Separate each claim form if using the continuous forms and remove all pin drive paper completely.
- Keep the file copy for your records.
- Mail HCFA 1500 claim forms separately from any other form type.

PROVIDING ATTACHMENTS WITH PAPER CLAIM FORMS

When a claim attachment is required, it must be directly behind the claim it supports and be identified with the patient's name and Medicaid ID Number. Attachments must be 8 ½ x 11", on white paper, and one-sided. Do not submit two-sided material. Multiple claims cannot be submitted with one attachment. Do not staple or paperclip the documentation to the claim form.

Mail claim forms with attachments flat with no folding in a 9" x 12" or larger envelope and print "Ext. material" (for extraneous material) on the outside. Do not put claims without attachments in this envelope. Mail claims without attachments separately.



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MAILING PAPER CLAIM FORMS

All paper claim forms and claim forms with attachments must be mailed to:



Michigan Department of Community Health
P.O. Box 30043
Lansing, MI 48909



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HCFA 1500 CLAIM FORM (front)

PLEASE
DO NOT
STAPLE
IN THIS
AREA



APPROVED OMB-0938-0008

CARRIER

HEALTH INSURANCE CLAIM FORM									
1. MEDICARE (Medicare #) <input type="checkbox"/> MEDICAID (Medicaid #) <input type="checkbox"/> CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (VA File #) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BUS LINGS (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>					2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				
3. PATIENT'S ADDRESS (No., Street)					4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
CITY					CITY				
STATE					STATE				
ZIP CODE					ZIP CODE				
TELEPHONE (Include Area Code)					TELEPHONE (INCLUDE AREA CODE)				
5. PATIENT'S RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					6. INSURED'S ADDRESS (No., Street)				
7. INSURED'S POLICY GROUP OR FECA NUMBER					8. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>				
11. INSURED'S POLICY GROUP OR FECA NUMBER					12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED: _____ DATE: _____				
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED: _____					14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY				
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY				
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES \$				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. _____ 2. _____ 3. _____ 4. _____					22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____				
23. PRIOR AUTHORIZATION NUMBER					24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. TYPE OF SERVICE D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS E. MODIFIER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. EWS J. COB K. RESERVED FOR LOCAL USE				
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>				
28. TOTAL CHARGE \$					29. AMOUNT PAID \$				
30. BALANCE DUE \$					31. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #				
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials) (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED: _____ DATE: _____				

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



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HCFA 1500 CLAIM FORM (back)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, "Carrier Medicare Claims Record," published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.



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HCFA 1500 Claim Completion Instructions

1. **Insurance:** Show the type of health insurance coverage applicable to this claim by checking the appropriate box.
- 1a. **Insured's I.D. Number:** Enter the patient's eight-digit Medicaid identification number.
2. **Patient's Name:** Enter the patient's last name, first name, and middle initial, if any.
3. **Patient's Birth Date AND Sex:** Enter the patient's eight-digit birth date (MMDDCCYY) and sex.
4. **Insured's Name:** If there is private or group health insurance covering the beneficiary, list the name of the insured (policy holder) here. When the insured and the patient are the same, enter the word SAME. If there is no other insurance, leave blank.
5. **Patient's Address:** Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.
6. **Patient Relationship to Insured:** Check the appropriate box for patient's relationship to insured when item 4 is completed.
7. **Insured's Address:** Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4 and 11 are completed.
8. **Patient Status:** Check the appropriate box for the patient's marital status and whether employed or a student.
9. **Other Insured's Name:** If the patient has more than one insurance in addition to Medicaid, enter the primary other insurance information in 11 through 11d and enter the name of the insured for the second commercial insurance here.
- 9a. **Other Insured's Policy or Group Number:** Enter the second insurance policy or group number.
- 9b. **Other Insured's Date of Birth and Sex:** Enter the insured's eight-digit date of birth (MMDDCCYY) and check the appropriate box for sex.
- 9c. **Employer's Name or School Name:** Enter the employer name or school name if applicable.
- 9d. **Insurance Plan Name or Program Name:** Enter the plan or program name of the second insurance.
- 10a. **Is Patient's Condition Related to Employment?:** Check YES or NO as appropriate.
- 10b. **Is Patient's Condition Related to Auto Accident?:** Check YES or NO. If YES, the two-digit state code must be entered and the date of the accident must be reported in item 14.
- 10c. **Is Patient's Condition Related to Other Accident?:** Check YES or NO. If YES, the date of the accident must be reported in item 14.
- 10d. **Reserved for Local Use:** Leave blank. Not used by Medicaid.
11. **Insured's Policy Group or FECA Number:** This item MUST be completed if there is other insurance including Medicare. Enter the insured's policy or group number or HIC (Medicare Health Insurance Claim) number and proceed to items 11a. – 11c. Do NOT enter Medicaid information here.
- 11a. **Insured's Date of Birth:** Enter the insured's eight-digit date of birth (MMDDCCYY) and sex if different from item 3.
- 11b. **Employer's Name or School Name:** Enter the employer's name or school name if applicable.
- 11c. **Insurance Plan Name or Program Name:** Enter the complete insurance plan or program name.



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- 11d. Is There Another Health Benefit Plan?** If there is a second health benefit plan, mark the YES box and complete fields 9 through 9d. If no other plan, mark NO.
- 12. Patient's or Authorized Person's signature:** Not required for Medicaid. The patient's Medicaid application authorizes release of medical information to DCH necessary to process the claim.
- 13. Insured's or Authorized Person's signature:** Not required for Medicaid. The patient's Medicaid application authorizes release of medical information to DCH necessary to process the claim.
- 14. Date of Current Illness, Injury or Pregnancy:** Enter the date of current illness, injury, or pregnancy as appropriate. If YES in item 10b or 10c the date of accident is required. Report the date as eight digits (MMDDCCYY).
- 15. If Patient has had a same or similar illness, give first date:** Leave blank. Not required by Medicaid.
- 16. Dates Patient Unable to Work in Current Occupation:** Leave blank. Not required by Medicaid.
- 17. Name of Referring Physician or other Source:** Enter the referring/ordering provider's first and last name, and professional designation (e.g., MD, DO). All covered services which are the result of a physician's order or referral must include the referring/ordering physician's name.
- 17a. I.D. Number of Referring Physician:** Enter the nine-digit Medicaid ID number of the referring/ordering provider. The first two digits must be the Medicaid provider type code and the last seven digits must be the Medicaid provider ID number.

Refer to the policy manual for situations where this number may be required. The referring/ordering provider ID number is always required when billing the following services:

Laboratory Services
Consultation Services
Nonemergency Ambulance Services

Ask for the ID number when the referral is made. If the referring/ordering provider is not enrolled in Medicaid, enter nine 8's (888888888). The provider's name and professional designation must be reported in field #17.

- 18. Hospitalization Dates Related to Current Services:** When services are provided during an inpatient hospital stay, enter the date admitted and, if available, the date discharged. Report the dates as eight digits (MMDDCCYY.)
- 19. Reserved For Local Use:** If services reported on the claim require documentation or special remarks, enter the information here.
- 20. Outside Lab/Charges:** Leave blank. Not required by Medicaid.
- 21. Diagnosis or Nature of Illness or Injury:** Enter the patient's diagnosis/condition that identifies the reason for the service. You must enter an ICD-9-CM code number and code to the highest level of specificity. Enter up to four codes in priority order (primary, secondary condition). Lab providers may use the laboratory examination code if a diagnosis is not available.
- 22. Medicaid Resubmission Code and Original Reference Number:** Complete only if replacing a previously paid claim. Enter a 7 under resubmission code on the left side of the box. Enter the ten-digit CRN of the paid claim you are replacing on the right side of the box.



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- 23. Prior Authorization Number:** Enter the nine-digit Medicaid authorization number for services requiring authorization. Refer to the policy manual for specific requirements. Following are some of the services that require authorization:

- Elective inpatient services
- Out-of-state ambulance transports
- Select medical equipment and supplies
- Select prosthetic and orthotic services
- Select vision services
- Transplant services
- Other services as described in the provider policy manual or the Medicaid Databases.

If billing for clinical lab services, the CLIA registration number must be reported here. The number is a 10-digit number with "D" in the third position.

- 24A. Date(s) of Service:** Enter the eight-digit date (MMDDCCYY) for each procedure, service or supply. List each date of service on a separate line. Both the "From" and "To" date must be completed.

Refer to the Special Billing for instructions on reporting the date of service in special circumstances.

- 24B. Place of Service:** Enter the appropriate two-digit place of service code from the list of CMS approved definitions for place of service below:

- 03 School:** A facility whose primary purpose is education.
- 04 Homeless shelter:** A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
- 05 Indian Health Service Free-standing facility:** A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
- 06 Indian Health Service Provider-based facility:** A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
- 07 Tribal 638 Free-standing facility:** A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
- 08 Tribal 638 Provider-based facility:** A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatient or outpatient.
- 11 Office:** Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
- 12 Home:** Location, other than a hospital or other facility, where the patient receives care in a private residence.
- 15 Mobile unit:** A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.



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- 21 **Inpatient hospital:** A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by or under the supervision of physicians to patients admitted for a variety of medical conditions.
- 22 **Outpatient hospital:** A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- 23 **Emergency room – hospital:** A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
- 24 **Ambulatory surgical center:** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
- 25 **Birth Center:** A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
- 26 **Military treatment facility:** A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
- 31 **Skilled nursing facility:** A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital
- 32 **Nursing facility:** A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
- 33 **Custodial care facility:** A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
- 34 **Hospice:** A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
- 41 **Ambulance – land:** A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
- 42 **Ambulance – air or water:** An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
- 50 **Federally Qualified Health Center:** A facility located in a medically underserved area that provides beneficiaries preventive primary medical care under the general direction of a physician.
- 51 **Inpatient Psychiatric facility:** A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
- 52 **Psychiatric facility - partial hospitalization:** A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
- 53 **Community mental health center:** A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation



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services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.

- 54 Intermediate care facility/mentally retarded:** A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals, but does not provide the level of care or treatment available in a hospital or SNF.
- 55 Residential substance abuse treatment facility:** A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
- 56 Psychiatric residential treatment center:** A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
- 60 Mass immunization center:** A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
- 61 Comprehensive inpatient rehabilitation facility:** A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
- 62 Comprehensive outpatient rehabilitation facility:** A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
- 65 End-stage renal disease treatment facility:** A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
- 71 State or local public health clinic:** A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
- 72 Rural health clinic:** A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
- 81 Independent laboratory:** A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
- 99 Other place of service:** Other place of service not identified above. (Provide description in item 19.)

Note: DCH does not recognize place of service 05, 06, 08, 26, 54, or 60 as locations for provision of covered services. Additionally, some locations may be covered only for select providers. Refer to your policy manual for more information.

24C. Type of Service: Leave blank. Not required by Medicaid.

24D. Procedures, Services, or Supplies (HCPCS Codes plus modifiers): Enter the code for the procedure, service, or supply rendered. Some procedure codes require the use of 2 character modifiers to accurately identify the service provided and to avoid delay or denial of payment. Up to two modifiers can



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be reported on one service line. If more than two must be reported, use the most pertinent modifier in the first position, modifier 99 in the second position and identify the additional modifier(s) in item 19. Refer to the Modifier section of this chapter for a list of the modifiers that must be reported to Medicaid. Additional information on use is found in the policy manual. Other modifiers may be reported for information purposes only.

If a code for the exact procedure cannot be found, use the appropriate unlisted services or Not Otherwise Classified (NOC) code listed within the service classification. Enter a complete description of the service in item 19 or attach the appropriate documentation. Do not use initials or abbreviations, unless they are universally known.

Any service reported to Medicaid for a Medicare/Medicaid eligible beneficiary that is an excluded or noncovered Medicare benefit, must be identified with modifier GY or GZ on the service line. Services for aliens aged 65 years old or older who do not have Medicare must be reported with a modifier GY on each service line.

24E. Diagnosis Code (Pointer): Enter the primary diagnosis code pointer or reference number (i.e. 1, 2, 3, or 4) from item 21, which reflects the reason the procedure was performed. The primary diagnosis must always be reported as the first number. An "E" code cannot be reported as a primary diagnosis. Up to 4 pointers (reference numbers) may be reported per line.
Do not report the actual diagnosis code in this item.

24F. Charges: Enter your usual and customary charge to the general public. Do not use decimals, commas, or dollar signs. Fifty dollars is 5000.

When billing Medicaid for services covered by Medicare, report the Medicare allowable amount.

When billing Medicaid for services covered by other third party carriers who have participating provider agreements in effect, bill the carrier's allowable amount.

For beneficiaries enrolled in a commercial HMO or a Medicare risk HMO, bill the fixed co-pay amount for the service as the charge.

24G. Days or Units: Enter the number of days or units. If only one service is performed, the number 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., mileage, allergy testing, injectable drug dosages, medical supply items). When multiple services are provided, enter the actual number provided.

For anesthesia claims, show the elapsed time in minutes. Convert hours into minutes and show the total minutes required for this procedure.

Refer to the policy manual for additional information on billing quantity in special circumstances.

24H. EPSDT / Family Plan: Leave blank. Not required by Medicaid.

24I. EMG – Emergency: Enter the appropriate emergency code:

Y = emergency

N = not an emergency

24J. Coordination of Benefits (COB): For paper claims, enter the appropriate code from the list below. If none of the following conditions apply, leave this item blank. **Note:** Do not bill Medicare covered and excluded services on the same claim.

1 = An insurance carrier other than Medicare made payment. Enter the payment in item 24K.



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2 = Commercial HMO fixed co-pay only. Item 24F should be the fixed co-pay amount only.

3 = An insurance carrier other than Medicare applied the charges to the deductible.

4 = Both Medicare and another carrier made payment. Enter the total payment in 24K.

5 = Medicare only made payment. Enter the payment in 24K.

6 = Medicare risk HMO co-pay only. Item 24F should be the fixed co-pay amount only.

7 = Medicare applied all charges to the deductible.

8 = The patient has other insurance (other than Medicare) and this service is not covered OR the patient's other insurance is terminated or expired. Indicate the reason for nonpayment in Box 19 (2300 NTE segment for electronic claims.) The policy number of the other insurance must be reported in box 11 even if the other insurance is terminated or expired.

9 = Spend-down liability. Enter the spend-down liability of the patient in item 24K.

Note: The Medicare EOB and/or the other insurance EOB must be submitted with the paper claim if you entered 1, 3, 4, 5, or 7. For electronic claims, the COB codes do not apply. The appropriate segments must be completed as explained in the transaction set and no EOB is required.

24K. Reserved for Local Use: For Medicaid, report the sum of Medicare payment, and any other insurance payment or spend-down liability. Spend-down liability is the amount that the patient owes on the service. Do not use decimals, commas, or dollar signs.

25. Federal Tax I.D. Number (check box/SSN or EIN): Enter your provider of service or supplier Federal Tax I.D. number (Employer Identification Number) or your Social Security Number. Check the box of the number reported. **Note:** The EIN or SSN reported here must correspond with the billing provider ID# in item 33.

26. Patient's Account Number: Enter the patient's account number assigned by the provider of service or supplier's accounting system. This field is to assist you in patient identification. As a service, account numbers reported here will be reported back to you on the remittance advice.

27. Accept Assignment (check box): Leave blank. Not required for Medicaid.

28. Total Charge: Enter total of charges from item 24F lines 1-6.

29. Amount Paid: Enter the total amount of all payments/spend-down liability reported in item 24K. If you did not indicate the other insurance amount on each service line, enter the lump sum amount in item 29 and attach the EOB to the claim. If there was no other payment, leave blank.

30. Balance Due: Enter the balance due (from Medicaid) by subtracting Amount Paid (item 29) from Total Charge (item 28).

31. Signature of Physician or Supplier including degrees or credentials: A signature is required. See Chapter I for the provider certification requirements and acceptable signatures for the claim form.

32. Name and Address of Facility Where Services Were Rendered (if other than home or office): Enter the name and address of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or the physician's office. When the name and address of the facility where the services were furnished is the same as the name and address shown in item 33, enter the word "SAME."



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- 33. Physician's, Supplier's Billing Name, Address, Zip code and Phone #, PIN# and Group #:** Enter the provider of service/supplier's billing name, address, zip code and telephone number.

Enter the provider's Medicaid nine-digit provider identification number on the bottom left side of the box next to "PIN#". Leave the space right of "GRP#" blank. The first two digits are the provider type code and the last seven digits are the assigned provider ID number for the location where the service was provided.

Note: The provider ID number reported here must correspond with the EIN or SSN reported in item 25.

Mandatory/Conditional Items

The following is a summary of mandatory and conditional claim completion requirements by item number.

Mandatory: Item is **required** for all claims. If the item is left blank, the claim cannot be processed.

Conditional: Item is required if applicable. Your claim may not be processed if blank.

Item	Status	Information
1 a	Mandatory	Enter the patient's 8-digit Medicaid ID number.
2	Mandatory	Enter the patient's last name, first name, middle initial, if any.
3	Mandatory	Enter the patient's 8-digit birth date (MMDDCCYY) and sex.
4	Conditional	Mandatory if the patient has insurance primary to Medicaid.
6	Conditional	If item 4 is complete check the appropriate box.
7	Conditional	Complete if items 4 and 11 are completed.
9	Conditional	Mandatory if item 11d. is YES.
9a	Conditional	Enter second insurance policy or group number for policyholder in item 9.
9b	Conditional	Enter date of birth (MMDDCCYY) and sex for policyholder in item 9.
9c	Conditional	Enter employer or school name for policyholder in item 9.
9d	Conditional	Enter insurance plan name or program name for policyholder in item 9.
10a	Mandatory	Check YES or NO if condition is employment related.
10b	Mandatory	Check YES or NO if condition is related to an auto accident. If YES, indicate the state postal code.
10c	Mandatory	Check YES or NO if condition is related to accident other than auto.
11	Conditional	Mandatory if patient has insurance primary to Medicaid. Enter primary insurance policy group number.
11a	Conditional	Enter the date of birth (MMDDCCYY) and sex for policyholder in item 4.
11b	Conditional	Enter the employer's name or school for policyholder in item 4.
11c	Conditional	Enter the insurance plan or program name for policyholder in item 4.
11d	Conditional	Check YES if appropriate and complete item 9-9d.
14	Conditional	If item 10b or 10c is YES, date of accident must be reported.
17	Conditional	Enter the referring/ordering physician's name as required.
17a	Conditional	Enter the 9-digit Medicaid provider ID# of the provider in item 17.
18	Conditional	Report the admit & discharge dates for services during an inpatient hospital stay.
19	Conditional	Enter documentation or remarks as required.
21	Mandatory	Enter the ICD-9-CM diagnosis code(s) that identify the reason for the service.
22	Conditional	Resubmit code 7 & the last paid 10-digit CRN is mandatory to replace a previously paid claim.



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Item	Status	Information
23	Conditional	Enter nine-digit Medicaid authorization number or ten-digit CLIA number as appropriate.
24A	Mandatory	Enter the eight-digit (MMDDCCYY) 'from' and 'to' date for each service.
24B	Mandatory	Enter the appropriate two-digit place of service code.
24D	Mandatory	Enter code and modifier (if appropriate) for the procedure, service or supply rendered.
24E	Mandatory	Enter the reference number(s) from item 21 that relates to the procedure/service. Report the primary diagnosis reference number first.
24F	Mandatory	Enter your charge without decimals, commas, or dollar signs.
24G	Mandatory	Enter the number of units.
24I	Mandatory	Enter appropriate code. Y = emergency N = not an emergency
24J	Conditional	Enter the appropriate COB code to define the involvement of Medicare or other insurance carriers.
24K	Conditional	Report amount of Medicare or other insurance payment or spend-down liability.
25	Mandatory	Enter the provider's Federal Tax I.D. or Social Security Number.
26	Mandatory	Enter the patient account number assigned by the provider or supplier.
28	Mandatory	Enter sum of charges in 24F.
29	Conditional	Mandatory if entries in 24K. Enter sum of entries in 24K.
30	Mandatory	Enter amount in 28 less amount in 29.
31	Mandatory	Signature of provider or supplier and date.
32	Conditional	Enter name & address of facility where services were rendered.
33	Mandatory	Enter the provider's 9-digit Medicaid ID number next to "PIN#" for the location of service billed.



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REPLACEMENT CLAIMS

Replacement claims (adjustments) are submitted when all or a portion of the claim was paid incorrectly or a third party payment was received after DCH made payment. When replacement claims are received, DCH deletes the original claim and replaces it with the information from the replacement claim. It is very important to include all service lines on the replacement claim, whether they were paid incorrectly or not. All money paid on the first claim will be taken back and payment will be based on information reported on the replacement claim only. Examples of reasons a claim may need to be replaced:

- to return an overpayment.
- to correct information submitted on the original claim.
- to report payment from another source after DCH paid the claim.
- to correct information that the scanner may have misread.

All the instructions for claim completion apply to completing a replacement claim. In addition, a replacement claim must include resubmission code 7 in the left side of Item 22 and the 10-digit CRN of the previously paid claim in the right side of Item 22. If the resubmission code of 7 is missing the claim cannot be processed as a replacement.

The provider ID number and beneficiary ID number on the replacement claim must be the same as on the original claim. If you receive payment under an incorrect provider ID number, submit a replacement claim using the same provider ID number as the original, complete one service line and leave all money fields blank. The entire payment made on the first claim will be taken back. A new claim may then be submitted for the correct provider ID number.

If you receive payment under the wrong beneficiary ID number, submit a replacement claim with the same beneficiary ID, complete one service line and leave all money fields blank. The entire payment made on the first claim will be taken back. A new claim may then be submitted using the correct beneficiary ID.

If **all** service lines of a claim are rejected, the services must be resubmitted as a new claim.

REFUND OF PAYMENT

Providers may refund payments to DCH when the entire amount paid for a claim needs to be returned due to overpayment, either from a third party resource or due to an error. A copy of the RA with a check made out to The State of Michigan in the amount of the refund should be sent to:

Department of Community Health
Cashier's Unit
P. O. Box 30223
Lansing, MI 48909



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GENERAL BILLING INFORMATION FOR THIRD PARTY COVERAGE

Third Party Liability (TPL): Payment resources available from both private and public insurance and other liable third parties that can be applied toward a beneficiary's health care expenses.

Third Party Payer: Any individual, entity, or program that is or may be liable to pay all or part of health care costs incurred by a beneficiary. This includes Medicare, an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), Champus, Workers' Compensation and automobile insurance.

It is the provider's responsibility to question the beneficiary as to the availability of Medicare and other insurance coverage prior to provision of the service. Medicaid is the payer of last resort. Providers must bill any other third party payers and receive payment to the fullest extent possible before billing the DCH.

Private health care coverage and accident insurance, including coverage held by or on behalf of a DCH beneficiary, is considered primary and must be billed according to the rules of the specific plan. DCH will not pay for services that would have been covered by the private payer if applicable rules of that private plan had been followed. A beneficiary with more than one level of private coverage must receive care at the highest level available. Providers are expected to take full advantage of the highest other insurance coverage from any third party resource (accept assignment, enrollment, participation). Medicare and other insurance coverage that have been made known to DCH are available from information contained on the beneficiary's Medicaid ID card. Detailed billing information about known insurance carriers is contained in the Carrier ID Listing in the Other Insurance Appendix of this manual.

Providers must always identify third party resources and report total third party payments when submitting a claim to DCH.

MEDICARE

Each provider must accept assignment of Medicare Part B for any services provided to Medicaid beneficiaries for whom coinsurance and deductible may be payable.

Medicare covered services should be submitted on one claim and any excluded services must be submitted on a separate claim. Do not mix covered and excluded services on the same claim.

If billing electronically, no EOB is necessary, as all required data are part of the format. However, in ALL cases where a provider is billing on the HCFA 1500 claim form, a copy of the Medicare EOB MUST be submitted with the claim.

The provider must always indicate Medicare's allowable amount as the charge (item 24F) and report the actual payment and/or deductible as instructed. DCH compares our maximum allowed fee screen to the Medicare payment amount. If the Medicare payment is less than our fee screen, we will pay the difference between the two. If the Medicare payment exceeds the DCH fee screen for the service, no payment will be made. If there is not a DCH established fee screen, we use Medicare's allowed amount and pay up to the full co-insurance and/or deductible.

If the beneficiary is in a Medicare Risk HMO, DCH will pay fixed co-pays on the services up to DCH's allowable amount for the service, as long as the rules of the HMO are followed. The fixed co-pay must be indicated in the charge field (item 24F) and report COB code 6 in item 24J.



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If the beneficiary has Medicare and Medicaid coverage, Medicaid will pay the Medicare Part B premium and allowable coinsurance and deductible amounts up to our maximum allowable fee screen.

If a Medicaid beneficiary is eligible for Medicare (65 years old or older) but has not applied for Medicare coverage, Medicaid will not make any reimbursement for services until Medicare coverage is obtained. The beneficiary must apply for Medicare coverage at a Social Security Office. Once they have obtained Medicare coverage, services may be billed to Medicaid as long as all program policies (such as time limit for claim submission) have been met.

The exception to requiring Medicare coverage for a Medicaid beneficiary who is 65 years old or older is when the beneficiary is an alien. An alien is a person who has been in the USA for less than five consecutive years, thus precluding them from being able to obtain Medicare coverage. For services to aliens who have Medicaid only, report modifier GY on each line and indicate "alien" in item 19.

OTHER INSURANCE

If a Medicaid beneficiary has commercial insurance coverage via a traditional insurance plan or is enrolled in a commercial health maintenance organization (HMO) or other managed care plan, the rules for coverage by the commercial plan must be followed. The beneficiary must seek care from network providers and authorization must be obtained as necessary. If the provider does not participate with the commercial insurance carrier or health plan, the beneficiary must be directed to contact their carrier for a list of participating providers. If participating providers are not available, the beneficiary must contact the DCH Program Recovery Unit for assistance in coordinating their Medicaid, CSHCS, and private coverage benefits. Beneficiaries should be referred to the Beneficiary Helpline at 800-642-3195. If the coverage rules of the commercial plan are not followed, DCH is not liable for payment of services denied by the plan for these reasons. Medicaid will only pay for services excluded from plan coverage if they are covered Medicaid services.

Medicaid will pay fixed co-pays up to our allowable screen as long as the rules of the commercial coverage plan (point of service, PPO, etc.) are followed. The beneficiary must use the highest level of benefits available to them under the policy. For example, Medicaid will not pay the point of service sanction amount for the beneficiary electing to go out of network. The provider must bill the fixed copay as the charge (item 24F) and report COB code 2 in item 24J. Information regarding the insurance must be supplied in item 11 through 11c of the HCFA 1500.

Providers may enter into agreements with third party payers to accept payment for less than their usual and customary charges. These arrangements are often called "Preferred Provider" or "Participating Provider Agreements," and are considered payment in full for services rendered. Since the insured has no further liability to pay, **DCH has no liability. DCH may only be billed if the third party payer has determined the insured/beneficiary has a legal obligation to pay.**

When billing on the HCFA 1500 claim form the provider must be able to show evidence of other insurance responses (explanation of benefits, denials, etc.) prior to billing DCH for covered services. **This documentation must be submitted with the paper claim form. If billing electronically, no attachment is necessary as all required data are part of the format.**

If payments are made by a commercial insurance, the amount paid, whether it is paid to the provider or the policyholder of the insurance, must be entered in item 24K on each service line as appropriate. If the provider does not accept direct payment from other insurance, or the other insurance company does not allow direct payment to the provider, it is the provider's responsibility to obtain the money from



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the policyholder. It is acceptable to bill the policyholder in this situation. Providers may not bill a Medicaid beneficiary unless the beneficiary is the policyholder of the commercial coverage.

If there is court-ordered support and the provider is having trouble collecting other insurance payments sent directly to the absent parent, the provider should contact the TPL area for assistance. Phone 1-800-292-2550 or email TPL@michigan.gov.

SPEND DOWN LIABILITY

If a patient is a "spend-down" beneficiary, the spend-down amount must be incurred before the beneficiary is eligible for Medicaid. The provider should bill the patient for the spend-down charges until the maximum is reached. The beneficiary does not have to pay these charges before becoming Medicaid eligible, but must incur the costs.

If the spend-down maximum is reached in the middle of a service and part of the charge is the patient's responsibility and part is Medicaid's responsibility, report the full charge for the service in item 24F of the service line. Report COB code 9 in item 24J and report the amount of the **patient's liability** in item 24K.



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For professional claims, many of the coding conventions described in CPT apply when submitting claims to the DCH. Additionally, CMS guidelines apply in many instances. Some services may require additional billing information in order to receive correct reimbursement from Medicaid, CSHCS, and SMP. The following are provided to assist providers in reporting information correctly.

Do not send documentation with your claim unless you are asked to do so. The use of modifiers replaces documentation requirements in many instances.

If you have unusual circumstances to report, contact our Provider Inquiry staff for help at 1-800-292-2550 or email ProviderSupport@michigan.gov.

AMBULANCE

All nonemergency ambulance services billed to the program must have the referring/ordering physician's name and ID # in item 17 and 17a.

When billing for ambulance services, providers must include the appropriate origin and destination modifier on any service line billing for mileage. The first character of the modifier is the origin code and the second character of the modifier is the destination code. (e.g. Use modifier RM for a transport from the residence to the emergency room.)

Origin and Destination Modifiers

D	Diagnosis or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential domiciliary custodial facility (other than a Medicare/Medicaid facility)
G	Hospital based dialysis facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of transportation
J	Non-hospital-based dialysis facility
M	Hospital emergency room
N	Skilled Nursing Facility (SNF) (Medicare/Medicaid facility)
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at a physician's office on the way to the hospital

No additional payment is made for the first 30 minutes of waiting time, i.e., the code may not be billed to the program. If more than 30 minutes of waiting time occurs, report the code and enter the appropriate number of time units in item 24g billing one time unit for each 30 minutes of waiting time over and above the first 30. Documentation regarding the circumstances must be submitted with the claim.

When billing a mileage code, enter the number of whole miles the beneficiary was transported in item 24g. Do not use decimals.



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ANCILLARY MEDICINE SERVICES

If an injectable drug is given on the same day as another service, the administration is generally part of the other service and cannot be reported separately. Only the procedure code for the cost of the drug should be reported.

Immunizations must be reported using the administration fee code(s) and the code identifying the type of vaccine given. Each vaccine/toxoid given must be reported in addition to the appropriate CPT administration code(s). The immunization administration is covered in addition to the vaccine even if an E/M visit is reported on the same day. Immunizations included in the Vaccine For Children (VFC) program are free so the charge for the vaccine must be reported as 000 (zero dollars).

For allergy immunotherapy services, only component services are billed. Report the number of doses of allergy extract or stinging insect venom prepared and billed at one time.

For diagnostic tests with global, professional and technical components, practitioners can bill the global service in the ambulatory setting or professional only component service in any setting. Practitioners cannot bill the technical component only.

ANESTHESIA SERVICES

Report anesthesia services with the 5-digit CPT anesthesia codes. Only one anesthesia service should be reported for a surgical session. Use the code of the major surgery.

Every anesthesia service must have an appropriate anesthesia modifier reported on the service line.

Report one time unit in item 24G for each minute of anesthesia time. Do not include base units.

If allowable surgical services are reported in addition to the anesthesia procedure, do not report time units for surgical services.

Do not report CPT Physical Status Modifiers or Qualifying Circumstance procedure codes to Medicaid.

DMEPOS

For medical supplies, the date supplied must be reported as the date of service.

For the Diaper and Incontinent Supplier Contract, the date the order is transmitted by the contractor to the fulfillment house shall be the date of service.

For both custom and non-custom DME (durable medical equipment) and P & O (prosthetics and orthotics) the date of delivery must be reported as the date of service.

When there is a loss of eligibility or a change in eligibility status (e.g., from fee-for-service to health plan enrollment or vice versa) between the time custom-made DME or P&O is ordered and delivered, the date of service should be reported as the order date rather than the delivery date.

In order to bypass the prior authorization requirement when billing for standard DME covered under the hospital discharge waiver service, you must report the discharge date in item 18.



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EVALUATION AND MANAGEMENT SERVICES

CPT E&M service guidelines apply for determining what level of care is appropriate. Generally CPT descriptions for E&M services indicate "per day" and only one E&M service may be reported per date of service.

Do not report a preventive medicine visit and an E&M visit for medical reasons on the same date unless the patient was seen at two separate times. If a patient is seen in the office at two different times of the day, for different levels of care, report on two service lines and indicate the time of each visit in item 19. If the same level of care visit is provided twice on the same day, report on one service line and use modifier 22. Indicate the time of day for each visit in item 19.

A procedure and a new patient E&M service on the same date should be reported using modifier 25 on the E&M service line.

Consultations require the referring/ordering provider's name and Medicaid ID # in item 17 and 17a.

To report emergency services in the office, report the applicable procedure (e.g., laceration repair) or the E&M office visit that represents the level of care provided.

Services such as telephone calls, missed appointments, interpretations of lab results cannot be billed as separate services.

HEARING AIDS

The date of delivery must be reported as the date of service.

When there is a loss of eligibility or a change in eligibility status (e.g., from fee-for-service to health plan enrollment or vice versa) between the time a custom hearing aid is ordered and delivered, the date of service should be reported as the order date rather than the delivery date.

LABORATORY SERVICES

CPT definitions for panels apply. All services in the panel must be provided and each test must be appropriate to the diagnosis or symptom for which the test was ordered.

All clinical lab services billed to the program must have a referring/ordering Medicaid provider name and ID# in item 17 and 17a.

All clinical lab services billed to the program must have a CLIA number in item 23.

If it is medically necessary to repeat the same clinical lab test on the same day for the same patient, report the first test on one line with no modifier and the second on the next line with modifier 91.

MATERNITY CARE SERVICES

CPT guidelines for reporting prenatal care and delivery services apply. Bill the global service as appropriate if the same physician or a single group practice provides prenatal care, delivery and postpartum care.



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The individual prenatal care or delivery codes should be billed when different physicians (not in the same group) provide the services.

The number of prenatal visits may vary depending on when the patient first seeks care. Typically a patient will have about 13 visits. For a high-risk pregnancy, report the appropriate E&M service when additional visits (beyond 13) are required for the high-risk condition. The diagnosis must be for the high-risk condition.

Postpartum care can be billed as a separate service only when provided by a physician or group practice that did not perform the delivery services.

For twin gestation, report the service on two lines with no modifier on the first and modifier 51 on the second. If all maternity care was provided, report the global OB service for the first baby, and report the appropriate delivery only code for the second baby using modifier 51. If multiple gestation for more than twins is encountered, report the first service on one line and combine all subsequent deliveries on the second line with modifier 51 and 22. Provide information in item 19 or submit an attachment to the claim explaining the number of babies delivered.

RADIOLOGY SERVICES

If bilateral x-rays are performed on extremities, report on two service lines with modifier RT on one and modifier LT on the other.

If the same x-ray is performed multiple times on the same patient on the same day, (e.g., before and after fracture care) report the appropriate quantity in item 24G.

For radiology services with global, professional and technical components, practitioners can bill the global service in the non-hospital setting or professional component service in any setting. Practitioners cannot bill the technical component only.

SURGERY

CPT surgery guidelines for add-on codes, separate procedures, starred procedures, and bilateral services generally apply.

CMS's global surgery guidelines apply. Use the appropriate modifiers to identify what service was provided.

When reporting post-operative care only for surgical procedures with 10 or 90-day global periods, the provider assuming the care must bill the date of the surgery and the appropriate surgical code. The claim cannot be submitted until after the patient is seen. Report the date care was assumed/relinquished in item 19.

For multiple surgical procedures performed during the same surgical session, report the primary surgery on the first service line with no modifier. Report the subsequent procedures performed during the same surgical session with modifier 51.

If two identical surgical or procedural services are provided on the same day to the same patient, and cannot be reported as a bilateral procedure, bill on two service lines with no modifier on the first line and modifier 51 on the second line. Multiple surgery rules apply. If more than two identical services



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are provided on the same day, the second and subsequent identical services must be combined on the second line. Report modifiers 51 and 22 and provide an explanation of the circumstances.

If a bilateral procedure is performed, report the bilateral code if available. When there is no code describing bilateral services, report the service on one line and use modifier 50.

Sterilization and hysterectomy consent forms may be faxed to the program for acknowledgement of proper completion before the service is billed to the program. The fax number is 1-517-241-7856. If completed properly, there is no need to submit a copy of the form with the claim. Indicate "consent on file" in item 19.

VISION

A routine eye exam must be reported by physicians and optometrists with one of the following procedure codes:

S0620 - routine ophthalmological examination including refraction; new patient

S0621 - routine ophthalmological examination including refraction; established patient

A routine eye exam includes history, visual acuity determination, external exam of the eye, binocular measure, ophthalmoscopy with or without tonometry, with plotting of visual fields, with or without biomicroscopy (slit lamp) and with or without refraction. A refraction cannot be billed separately.

E&M vision codes from CPT should only be billed with a medical diagnosis.

Report the date eyeglasses are dispensed as the date of service in item 24A. If eligibility or enrollment status changes after eyeglasses are ordered but before they are delivered, the order date of the eyeglasses must be reported as the date of service in item 24A.

MISCELLANEOUS

All unlisted codes require documentation of the services provided in order to be considered for payment.

Use ICD-9-CM coding conventions to report the diagnosis code(s) at the highest level of specificity. E codes cannot be reported as a primary diagnosis. If an E code is reported as primary, or if a code requiring a fourth or fifth digit is reported with fewer digits (truncated), the claim cannot be paid.

For elective services requiring prior authorization, authorization must be obtained before the service. If approved, a letter confirming coverage or denial of the service will be sent back to you along with a nine-digit PA number. **Do not submit the letter to the program when billing. Report the PA number in item 23.**



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Procedure codes may be modified under certain circumstances to more accurately represent the service or item rendered. There are three levels of modifiers, Level I being those included in CPT and updated annually by the American Medical Association, Level II recognized nationally and updated annually by HCFA, and Level III, those assigned for use within an individual state. All three levels are two digits.

Definitions and use of Level I modifiers can be found in the annual edition of the CPT. Definitions of Level II modifiers are found in the annual edition of HCPCS National codes. Definitions of Level III modifiers can be found in publications from the DCH. Providers should refer to their policy manual for more information on the use of these modifiers.

The modifiers listed below must be reported when applicable and affect the processing and/or reimbursement of claims billed to the DCH for Medicaid, CSHCS, and SMP beneficiaries. Other modifiers in Level I and II may be used to provide additional information about the service but won't be considered in the processing of your claim.

AMBULANCE

Refer to the Special Billing Section on Ambulance for information on origin and destination modifier use.

GM	Multiple patients on one ambulance trip.	Enter on the transport service line for 2 nd or subsequent patient when more than one patient is transported. Reduces reimbursement for the 2 nd or subsequent patient transported. Do not report for the first patient.
AS	Out of state transfer	Report on all out of state transfers. Enter the PA number in item 23 for non-emergency out of state transfers.

ANESTHESIA

Anesthesia services billed without an appropriate modifier will be rejected.

47	Anesthesia by Surgeon	Anesthesia procedure codes billed with this modifier will not be paid. General anesthesia provided by the surgeon is not covered.
AA	Anesthesia Services Performed Personally By Anesthesiologist:	Determines reimbursement for anesthesia services reported with codes 00100-01999.
AD	Medical Supervision By A Physician: More Than Four Concurrent Anesthesia Procedures	Determines reimbursement for anesthesia services reported with codes 00100-01999.
QK	Medical Direction Of 2,3 Or 4 Concurrent Anesthesia Procedures Involving Qualified Individuals	Determines reimbursement for anesthesia services reported with codes 00100-01999.
QX	CRNA service with medical direction by a physician	Determines reimbursement for anesthesia services reported with codes 00100-01999.



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QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist:	Determines reimbursement for anesthesia services reported with codes 00100-01999.
QS	Monitored anesthesia care service:	Report in addition to the appropriate anesthesia modifier to identify MAC services reported with codes 00100-01999.
QZ	CRNA service: without medical direction by a physician:	Determines reimbursement for anesthesia services reported with codes 00100-01999.

COMPONENT BILLING

Certain procedures are a combination of a professional component and a technical component and must be reported in order to receive reimbursement.

26	Professional Component	Must be reported when billing only the professional component of a procedure. Providers are limited to billing the professional component for certain services in a facility setting.
TC	Technical Component	Reserved for facility billing. Practitioners should not report.

DMEPOS

CS	Contoured Seating for Wheelchairs	Use for the purchase of a custom seating section for a wheelchair. Use with procedure codes Y4290 and Y4292.
LA	(Large) Child Diaper	Use for purchase of large size child diaper.
LB	Long Term Use of a Specialized Bed	Use with procedure codes K0193 and K0194 for long-term rental period after the first 10 months of rental period has been completed.
LF	(Lofric) intermittent urinary catheter, straight tip	Use with procedure codes A4351 and A4352 to specify purchase of the Lofric brand intermittent urinary catheter.
LG	(Large) Adult Diaper	Use for purchase of a large size adult diaper.
LT	Left Side of the Body (used to identify procedures performed on the left side of the body)	Must be reported with select Prosthetic and Orthotic items to identify the left side of the body for use. Also will allow payment of bilateral RT and LT devices placed on the same date of service.
SM	(Small) Adult Diaper	Use for purchase of small size adult diaper.
MD	(Medium) Adult Diaper	Use for the purchase of a medium size adult diaper.
NU	New DME equipment	Use for the purchase of a <i>new</i> DME item.
PS	Addition of Power Tilt-in-Space	Use for the purchase of a power tilt-in-space to a wheelchair base. To be used with procedure codes K0011, K0012, K0013, & K0014.
PT	Addition of Power Recline and Tilt-in-Space	Use for the purchase of a power recline and tilt-in-space to a wheelchair base. To be used with procedure codes K0011, K0012, K0013, & K0014.

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RP	Replacement and repair, "RP" may be used to indicate replacement of DME, Orthotic and Prosthetic devices which have been in use for some time. The claim shows the code for the part, followed by the "RP" modifier and the charge for the part.	For repair of either DME or Orthotic/Prosthetic devices. Provider will report the procedure code that requires replacement and use the RP modifier. For unusual DME situations, report E1340 – Repair of non-routine service for durable medical equipment requiring the skill of a technician, Labor Component, per 15 minutes. Use E1399 for the item that needs to be repaired or replaced if no existing code is appropriate. For the items related to wheelchairs, use K0108. All three codes require prior authorization and manual pricing. For Prosthetics/Orthotics, if the description of the code is designated as a replacement code, the RP modifier should not be used. For unusual situations, report L7520 to report a labor charge for adjustments or repairs for prosthetics and L4205 for orthotics. For minor materials where there is no established HCPCS code, report L7510 for prosthetics and L4210 for orthotics. These require prior authorization and manual pricing.
RR	Rental (use the "RR" modifier when DME is to be rented)	For monthly rental rate of DME items.
RT	Right Side of the Body (used to Identify Procedures performed on the right side of the body)	Must be reported with select Prosthetic and Orthotic items to identify the right side of the body for use. Also will allow payment of bilateral RT and LT devices placed on the same date of service.
RW	Addition of Power Recline	Use for the purchase of a power recline to a wheelchair base. To be used with procedure codes K0011, K0012, K0013, & K0014.
SB	Short Term Use of a Specialized Bed	Use with procedure codes E0193 and E0194, up to the first 10 months of rental.
TS	Single unit enema e.g. (Therevac)	Use with procedure code Y3623 to specify purchase of the Therevac brand item.
UE	Used durable medical equipment	Use for the purchase of used DME equipment that is not over 3 years old and meets the Medicaid requirements for equipment.
WD	Extremely Heavy Duty: Can support client weighing > 350 lbs.	Use for the purchase of an extremely heavy-duty modification to a wheelchair. To be used with procedure codes K0006 and K0007.
WE	Extra Wide and Extremely Heavy-Duty: can support patient weighing >350 lbs. And has seat width of > 22".	Use for the purchase of an extra wide and extremely heavy-duty modification to a wheelchair. To be used with procedure codes K0006 and K0007.
WW	Size Small	Use for purchase of small size for medical supplies.
WX	Size Medium	Use for purchase of medium size for medical supplies.
WY	Size Large	Use for purchase of large size for medical supplies.
XL	(Extra Large) Adult Diaper	Use for purchase of extra large size adult diaper.
Y3	Footwear Code	Use for purchase along with specific footwear procedure code for additional charge for split size.
YD	Youth Diaper	Use for purchase of youth size diaper.



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EVALUATION AND MANAGEMENT SERVICES

21	Prolonged Evaluation and Management Services	Use to report a service that is greater than that usually required for the highest level of an evaluation and management service. A report or remarks explaining the service is required.
24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	E&M services unrelated to the surgery and billed by the surgeon during the postoperative period of a global surgery are not payable without this modifier.
25	Significant, Separately Identifiable Evaluation and Management Services by Same Physician on Same Day of the Procedure	E&M services reported without modifier 25 and billed in addition to other procedures/services on the same day are not payable. Allows significant separately identifiable E&M services to be paid without review. Subject to postpayment audit.
57	Decision for Surgery	Required for an E & M service provided the day of or the day before a procedure with a 90-day global period to indicate that the service was for the decision to perform the procedure.

GENERAL BILLING

22	Unusual Procedural Services	Report/remarks required.
99	Multiple Modifiers	Identifies that more modifiers are necessary than allowed by the format (2 on paper claims or 4 in the electronic format). The second or fourth modifier must be "99" and the additional modifiers must be indicated in item 19 or the appropriate electronic remark area.
GC	Service performed by resident under direction of teaching physician.	Report to identify services provided by resident in presence of teaching physician.
GE	Service performed by resident under primary care exception	Report to identify primary care services provided by a resident without the presence of the teaching physician under the primary care exception.
LT	Left side (used to identify procedures performed on the left side of the body)	Allows appropriate multiple line reporting of select procedures performed on the right and left side of the body on the same day.
Q5	Service furnished by substitute physician under a reciprocal billing arrangement	The name of the physician providing the service must be reported in item 19.
Q6	Service furnished by a locum tenens physician	The name of the physician providing the service must be reported in item 19.
RT	Right side (used to identify procedures performed on the right side of the body)	Allows appropriate multiple line reporting of select procedures performed on the right and left side of the body on the same day.



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LABORATORY

90	Reference Lab	Identifies that services were referred to specialty lab.
91	Repeat Clinical Diagnostic Laboratory Test:	Use to identify a medically necessary repeat test done on same date.
QW	CLIA waived test:	Identifies CLIA waived tests as required.

MEDICARE

GY	Excluded Medicare Benefit	Report this modifier to identify services that are excluded from Medicare coverage. Also report to identify services for aliens 65 years old and older.
GZ	Medicare denied as not reasonable or necessary	Report this modifier to identify services determined not reasonable or necessary by Medicare.

SURGICAL SERVICES

50	Bilateral Procedure	Report to identify that bilateral procedures were performed during the same operative session. Reimbursement is 150% of the fee for the procedure or the provider's charge if bilateral reporting is appropriate.
51	Multiple Procedure	Use to report multiple procedures during the same operative session. Report on each additional procedure, not on the primary procedure. Determines payment at 100%, 50%, 50%, etc. when appropriate.
52	Reduced Services	Report if a service or procedure is partially reduced or eliminated at the physician's discretion. A report or remarks are required to determine reimbursement.
53	Discontinued Procedure	Report if a surgical or diagnostic procedure is terminated after it was started. A report or remarks are required to determine reimbursement.
54	Surgical Care Only	Reported by the surgeon for surgical procedures with 10 or 90 day global periods when all or part of the post op care is relinquished to a physician who is not a member of the same group. Reimbursement will reduced to the surgical care rate only.
55	Postoperative Management Only	Reported by the physician furnishing postop management only. Report the surgical procedure with the date of surgery and the date care was relinquished/assumed in Box 19.
56	Preoperative Management Only	Do not report. Preoperative management is part of the surgical care and is not covered separately. Claims billed with modifier 56 will be rejected.
58	Staged Or Related Procedure Or Service By The Same Physician During The Postoperative Period.	Allows payment for subsequent surgical procedures performed during the global surgery period that meet certain requirements. Do not use in place of modifier 78.
59	Distinct Procedural Service	Report/remarks required. Do not report if another modifier is more appropriate.
62	Two Surgeons	Determines reimbursement when two surgeons were involved in the same surgery.
66	Surgical Team	Determines reimbursement for complex surgery requiring a surgical team. A report or remarks are required.
76	Repeat procedure by same physician	Report when a procedure or service is repeated by the same physician subsequent to the original service.



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78	Return to the Operating Room for a Related Procedure During the Postoperative Period:	When appropriate, allows payment for related services (complications) requiring a return to OR during the postoperative period. Payment is reduced to operative care only.
79	Unrelated Procedure or Service by Same Physician During Postoperative Period	When appropriate allows payment for services during the postoperative period unrelated to the original surgery.

SURGICAL ASSISTANCE

80	Assistant Surgeon	Reimbursement for services at the assistant surgeon rate. If reported with modifiers 54, 55, 58, 59, 78, 79 the claim will not be paid.
81	Minimum Assistant Surgeon	Use modifier 80 or 82 to bill surgical assistance. Claims billed with modifier 81 will be rejected.
82	Assistant Surgeon (when qualified resident surgeon not available)	Reimbursement for services at the assistant surgeon rate. If reported with modifiers 54, 55, 58, 59, 78, 79 the claim will not be paid.

VISION

VG	Industrial thickness polycarbonate lenses	Determines payment rate to contractor.
VH	High index lenses	Determines payment rate to contractor.
VI	Industrial thickness lenses	Determines payment rate to contractor.
VC	Polycarbonate lenses	Determines payment rate to contractor.
VP	Aphakic patient	Report to identify that service is for aphakic patient.
55	Postoperative management only	Reported by an optometrist (with TPA certification) for select services when a physician performs the surgical procedure and relinquishes the follow-up care to the optometrist.



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GENERAL INFORMATION

The DCH establishes a payment amount for all procedure codes in our claims processing system. All other resources, including Medicare, must be billed prior to billing Medicaid, Children's Special Health Care Services (CSHCS), and the State Medical Program (SMP). When a payment has been made by another resource, our payment is determined by comparing our normal payment (or your charge, whichever is less) to the amount paid by the other resource.

The remittance advice (RA) informs you of the action taken on your claims. It shows the claims processed for payment, new claims that pended, and claims that were rejected. The codes next to each service line explain the action taken. When you review your RA refer to the Explanation Codes Appendix in this manual for definitions of each code.

Every individual provider receives a paper RA. If claims are submitted electronically, the electronic biller (the billing agent) receives an electronic RA that includes all claims submitted by the agent. Information on the electronic RA can be found on the DCH website in the "MDCH Electronic Billing Manual" at http://www.mdch.state.mi.us/msa/mdch_msa/UniformBilling/index.htm. As versions and specifications change, the website will be updated.

The DCH processes claims and issues checks (warrants) every week unless special provisions for payments are included in your enrollment agreement. We send you a RA with your check to explain the payment made for each claim. If no payment is due, you still receive a RA if your claims are pended or rejected. If you did not submit claims for the current pay cycle and no action is taken on previously pended claims, a RA is not printed.

Note: If the total amount approved for your claims on any one RA is less than \$5.00, you do not receive a check for that pay cycle. Instead a balance is held until your approved claims accumulate to an amount equal to or more than \$5.00. Twice a year (usually in June and December) all amounts of less than \$5.00 are paid.

If a claim does not appear on a RA within 30 days of submission you should submit a new claim. Verify that the provider ID# and beneficiary ID# are correct.

REMITTANCE ADVICE MESSAGES

A message may be printed on the next to the last page of your RA or it may be inserted as a flyer. The messages give you current information about policy and payment issues that affect the way you bill and are paid. For example, we send messages to:

- clarify a billing instruction,
- explain problems in our payment system,
- remind you of a change in our programs,
- announce a delay in payment, or
- notify you of billing seminars.

REMITTANCE ADVICE HEADER

The RA header contains the following information:



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- Provider ID No. and Provider Type: This is the provider ID from your claim. The first two digits of your provider ID appear in the provider type box and the last 7 digits appear in the provider no. box.
- Provider Name: This is from the DCH provider enrollment record for the provider ID submitted on the claim.
- Pay Cycle: This is the pay cycle number for this RA.
- Pay Date: This is the date the RA is issued.
- Page No: Pages of your RA are numbered consecutively.
- Federal Employer ID Number or Social Security Number: This is in small print in the upper right corner and is unlabeled. The number on your claim must match the billing provider ID number on file with the Department of Community Health and it must be a valid number with the Department of Treasury. We cannot issue a check if there is a discrepancy between the number on file with the DCH or the Department of Treasury.

Note: If any of the information is incorrect, contact our Provider Enrollment Unit at 517-335-5942 to make changes in your enrollment information.

REMITTANCE ADVICE CLAIM INFORMATION

Your claims appear on the RA in alphabetical order by the patient's last name. If there is more than one claim for a patient they appear in Claim Reference Number (CRN) order under the beneficiary's name.

Claim Header

- Patient ID Number: Prints the patient Medicaid ID number entered on your claim
- Patient Name: Prints the name associated with the patient ID from our eligibility file. If the patient ID number is not entered on your claim or is not valid, we print zeros and reject these claims. These claims will print first on your RA.

Service line Information

- Prov. Ref. No: We print the leftmost 14 characters of the patient account number you entered on the claim.
- Claim Reference Number: We assign a ten-digit CRN to each claim. If your claim has more than one service line, the same CRN is assigned to each line. The first four digits of the CRN are the Julian Date the claim was received by us. The fifth through tenth digits are the sequential claim number assigned by the DCH.

For example in CRN 0223112345, 0 is the year 2000, 223 is the day of the year, and 112345 is the sequence number. The combination of Julian date and sequence makes a unique number that is assigned to each claim. When you ask about a particular claim use the CRN and Pay date as a reference.

The ten-digit CRN is followed by a two character input ID. (0223223445-XX) If a service bureau submitted your claim this will be the service bureau ID. If you submitted a paper claim this will be a scanner identifier.

- Line No: This identifies the line number where the information was entered on your claim.



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- Invoice Date: We print the date from your claim or the date the claim was processed by the system.
- Service Date: We print the 'from' date of service from your service line.
- Diagnosis Code: We print the diagnosis code indicated for the service line.
- Procedure Code/Mod: We print the procedure code and first modifier from your service line. If the DCH recoded your service, then an informational edit will appear in the explanation code column.
- Qty: We print the quantity from your service line. If the DCH changed your quantity, an informational edit will appear in the explanation code column.
- Amount Billed: We print the charge from your service line.
- Amount Approved: This is the amount we approved for the service line. Pended and rejected service lines show the amount approved as zero (00). Zero also prints when no payment is due from us, for example, when other resources made a payment greater than our usual payment.
- Source Status: This column shows the source of funding for paid lines and shows the status of unpaid lines. One claim may have several source codes. The status codes for paid lines are:

MA	Medicaid
SMP	State Medical Program
CC	Children's Special Health Care Services
CC/MA	Children's Special Health Care Services and Medicaid
CIR	Cuban/Indochinese Refugee or Repatriate
CO-DED	Medicare patient

- The status codes for unpaid lines are:

REJ	The service line is rejected.
PEND	The service line is pending and is being manually reviewed.

Note: If one service line on the claim is pending, then all service lines have a PEND status.

- Explanation Codes: Explanation Codes indicate the reason a service line was rejected or pended. They also give information about service lines and may point out potential problems. A complete listing of explanation codes and the code indicators can be found in the Explanation Code Appendix. Reviewing the codes printed on your RA will provide you with information that can assist you with future claims.
- Invoice Total: Totals for the Amount Billed and the Amount Approved print here.

Insurance Information: If our beneficiary files show other insurance coverage, the carrier name, policy number, effective dates and type of policy (e.g. vision, medical) print below the last service line information.

History Editing: Certain edits compare the information on your claim to previously paid claims. In some cases, information about the previous claim will print to your RA. This information prints directly under the service line to which it relates.

Page Total: This is the total Amount Approved for all the paid service lines on the page. If a claim form has service lines appearing on two RA pages, the page total will include only the paid lines printed on each RA page. **Note:** Amounts for pended and rejected service lines are not included in the page total.



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GROSS ADJUSTMENTS

Gross adjustments are initiated by DCH. A gross adjustment may pertain to one or more claims.

We notify you in writing when we are making an adjustment. You should receive the notification before the gross adjustment appears on your remittance advice (RA).

Types Of Gross Adjustments

One of the following adjustment codes prints in the Amount Billed column.

- GACR is Gross Adjustment Credit. This appears when you owe us money. We subtract the gross adjustment amount from your approved claims.
- GADB is a Gross Adjustment Debit. This appears when we owe you money. We add the gross adjustment amount to your approved claims on the current payroll.
- GAIR is a Gross Adjustment Internal Revenue. We print this code when you have returned money to us by check instead of submitting a replacement claim. It is subtracted from your YTD (Year To Date) Payment Total shown on the summary page of your RA.

REMITTANCE ADVICE SUMMARY PAGE

The Summary page is the last page of the RA and gives totals on all claims for the current payroll and year-to-date totals from previous payrolls.

This Payroll Status: We print the total number of claims and the dollar amount for the current payroll. This includes your new claims plus your pended claims from previous payrolls that were paid, rejected, or pended on the current payroll.

- Approved: This is the number of claims from this payroll with a payment approved for every service line. The dollar amount is the total we approved for payment.
- All Other Pends: This is the number of claims from this payroll that are pending. The dollar amount is the total charges you billed.
- Rejected: This is the number of claims from this payroll with a rejection for every service line. The dollar amount is the total charges you billed.
- App'd/Rejected: This is the number of claims from this payroll with a combination of paid and rejected service lines. The amount next to App'd Claim Lines is the total we approved and the amount next to Rejected Claim Lines is the total charge you billed.

Total Pends in System: This is the number of your new and unresolved pended claims in the system and related total charges.

Previous YTD (Year to Date) Payment Total: This is the total amount paid to you for the calendar year before any additions or subtractions for this payroll.

Payment Amount Approved This Payroll: This is the total dollar amount approved for this payroll.

Actual Payment Due This Payroll To Provider: This amount is the Payment Amount Approved plus any balance due to you and minus any balance owed from you.



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Payment Made This Payroll: This is the amount of your check issued for this payroll.

New YTD Payment Total This Payroll: This is your total payment for the calendar year including payments made on this payroll.

SMP Total Approved This Payroll: The total amount due to you for State Medical Program services approved this payroll. A separate check will be issued for this amount.

Balance Owed or Balance Due: One or more of the following messages prints if you have a balance owed or a balance due.

- **Balance Due to Provider by MDCH:** This appears if the payment amount approved is less than \$5.00 or a State account is exhausted.
- **Balance Owed by provider to MDCH:** This appears when money is owed to us, but you do not have enough approved claims from a particular State account (e.g., CC or SMP) to deduct what is owed.
- **Previous Payment Approved, Not Paid:** This appears if a balance is due from us on the previous payroll.
- **Previous Payment owed by Provider to MDCH:** This prints when a balance is due from you on a previous payroll.

Pay Source Summary: This identifies the dollar amounts paid to you from the designated State accounts.

PENDED AND REJECTED CLAIMS

When your claim is initially processed the Source Status column on the RA identifies which service lines have been paid, rejected or pended. The RA explanation code column lists edits which apply to each service line.

Rejections: If your service line is rejected, an explanation code or codes followed by an R will print in the explanation code column of your RA (e.g. 092R). You should review the definition of the codes found in the Explanation Code Appendix to determine the reason for the rejection.

Pends: If any line of your claim pends for manual review, PEND prints in the Source Status column for all the service lines on your claim. An explanation code or codes followed by a P (e.g. 936P) will print in the explanation code column of your RA. These pended claims will not print again on your RA until:

- the claim is paid or rejected, or
- is pended again for another reason, or
- has pended for 60 days or longer.

Note: After a claim initially pends it may pend again for a different reason. In that case, a # symbol (#) will print in front of the CRN on the RA to show that it is pending again for further review. CRNs may also appear with a # symbol if they have pended 60 days or longer.



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If we determine that the claim can continue through the claims processing system the edit will appear with an asterisk * (e.g. 936*) on your RA. If we determine that the service line should be rejected for the reason specified by the pending edit, an additional edit will be added to the service line (e.g. 727R, 936P) and the Source Status code on the line will say REJ.

When your claim is pended wait until it is paid or rejected before you submit another claim for the same services.



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JULIAN CALENDAR

Day /Month	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	--	88	119	149	180	210	241	272	302	333	363
30	30	--	89	120	150	181	211	242	273	303	334	364
31	31	--	90	---	151	---	212	243	---	304	---	365

For leap year, one day must be added to number of days after February 28. The next three leap years are 2004, 2008 and 2012.

Example: claim reference # 1351203770-59
 1 = year of 2001
 351 = Julian date for December 17
 203770 = consecutive # of invoice
 59 = internal processing



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The DCH has numerous resources to assist you with billing services to Medicaid.

Michigan Department of Community Health Website: Go to: www.mdch.state.mi.us. Click on *Medical Services Administration*, then *Information for Medicaid Providers* where you will find Medicaid related information including a listing of health plans, a sanctioned provider list, databases listing covered procedure codes, fee screens and other payment indicators, the Electronic Billing Manual, policy bulletins and other relevant Medicaid information.

Electronic Billing Resources: For information regarding the submission of electronic claims and associated transmission and format files including the acceptable versions, see the MDCH Electronic Billing Manual on the DCH website at http://www.mdch.state.mi.us/msa/mdch_msa/UniformBilling/index.htm.

Use the following addresses to submit your questions on electronic billing, request forms to become an authorized billing agent, or to schedule electronic testing of claims. Be sure to include your name, phone number and address with all inquiries.



E-mail: AutomatedBilling@michigan.gov.



Or write to: Michigan Department of Community Health
Medicaid EDI Billing Coordinator
P. O. Box 30043
Lansing, MI 48909-7543

Provider Inquiry: Direct questions on program coverages, claim completion instructions, and information printed on the remittance advice (RA) to:



1-800-292-2550

Review the information in the manual pertaining to the policy or procedure before you call. Have your Medicaid provider ID number, the claim information and the RA (if applicable) when you call. Ask for the telephone representative's name so you can speak to the same person if a follow-up call is necessary.


Written Requests: You may email questions or send them hard copy by mail. Include your name, phone number, provider ID #, beneficiary name and ID#, CRN and pay cycle as appropriate. Include a clear concise statement of the problem or question.



E-mail: ProviderSupport@michigan.gov




Or write to: Research and Analysis
Michigan Department of Community Health
P. O. Box 30479
Lansing, MI 48909

Provider Training Sessions:  1-517-335-5149. DCH staff conducts provider-training sessions throughout the state targeted to specific provider groups. Receive information on schedules, training session content, and reservations.





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TPL (Third Party Liability) Help: Staff resolves calls regarding other insurance additions and terminations, billing problems involving other insurance, and disenrollment from health plans when there is commercial HMO coverage.

 1-800-292-2550


 E-mail: TPL@michigan.gov

TPL Beneficiary Helpline:  1-800-642-3195. Only beneficiaries should be referred to this number for assistance with locating participating providers for their commercial insurance carrier or plan.

Provider Enrollment Help:  1-517-335-5492. Requests for enrollment applications or questions about current enrollment, and all change of ownership, change of address, or change in federal tax employer ID numbers or social security numbers should be directed here.

Manuals and Forms:  1-517-335-5158 for information on ordering provider manuals and forms, or to request copies of published bulletins and numbered letters.

Sterilization and Hysterectomy Procedure Consent forms: Fax completed forms to 1-517-241-7856.

Miscellaneous Transactions Unit (MTU):  1-517-335-5477 to get information on submitting out of state or non-enrolled provider claims.

Eligibility Verification System: Use to determine beneficiary's eligibility status, health plan enrollment status, and other insurance coverage.

Medifax:  1-888-696-3510 Automated Voice Response System